Proposal to Reduce Child Deaths Due to Maltreatment

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INTRODUCTIONS - I began with fatal child abuse in 1975, planning and building a structure for the world's first Child Death Review team. Deanne Tilton Durfee ran the largest Interagency Council on Child Abuse/Neglect housed this team in 1978. That gives us 71 years experience that continues today. I will present some of our experience and note people we admire.

OUR BACKGROUND Both of us had earlier experience. Deanne began as a line welfare worker and was asked to join a new profession, child protective services. She can still find the memory and image of a baby who later died. She helped create the LA County Dependency Court System and became a manager. She was asked to manage a small multiagency forum that she grew to 32 agencies, 20 committees, 12 community based child abuse councils, five conferences, multiple reports and a private charity. I helped create our annual report on child death and a report on multiagency data systems. Deanne became chair of the US Advisory Board on Child Abuse/Neglect that used our experience and contacts to create A National Shame, a report Fatal Child Abuse/Neglect in the US. Randy Alexander MD now in Florida helped with that report and later was the editor of the primary text on Child Fatality Review.

San Diego County formed the second Child Death Team Review in 1982. Their work suggested that such deaths peaked at age three. Our experience allowed me to suggest changes in their program that helped them find infants that they had been missing. Other counties and then other states followed. Canada and Australia had team reports in 1994. ICAN became the National Center on Child Fatality Review, the major source of support to others forming teams. We shared our work nationally and then internationally. The last state was added in 2001.

ICAN was the primary program and I was the primary advocate for teams from 1978 into this century and I had few people to back me up. I met with team members from half of the states and talked with most of the rest by phone. I initiated, chaired and managed the California state team with no money or legal mandate. The Coalition of teams in Southeastern States gave me the title of "Father of Child Death Review". I earned that title and value those words.

EARLY DAYS The early days were anchored in peer support. Teams called each other to ask for help. Regional groups formed that continue today. The Southeastern states have the largest group of teams with states from Virginia to Florida to Texas.

MEDIA - Much of the growth came in the 1990s with early press coverage with stories on individual cases. A series of articles in the Atlanta Constitution were nominated for a Pulitzer

Prize. A Washington Post reporter was given that award and a series in the Chicago Tribune received a Pulitzer. Media become part of this process. The death of Lisa Steinberg in 1987 was major print and TV news. Other famous cases followed with Susan Smith and Eli Creekmore. My computer news review noted most reporters were female as if this was a female issue. Most stories with pictures were white male toddlers. The years 2000 to 2010 brought complaints of agency failure and occasional Child Death Review team reports noting success with prevention programs. These stories are now larger with Governors or senior manager and media and arguments on confidentiality. Congress and federal officials have joined us.

TEAM REPORTS ICAN shared team reports in the 1990s with an annual press release. Newspapers TV and radio reporters were given different stories to cover with homicide, suicide or accident prevention. The LA Times Magazine had a cover picture of the LA County Team titled “The Worlds Worst Job”. The public learned ways to protect children. Media contacts have been used for prevention programs including pool safety, Safe Surrender and Safe Sleeping.

FORMAL LITERATURE My formal medical literature includes *Origins and Clinical Relevance of Child Death Review* 1992, JAMA, Fatal Child Abuse Chapter Henry Kempe A 50 Year legacy 2012, Springer. Most of my work has been published in local reports and protocols with topics that needed to be addressed. Richard Bullock wrote a document for the creation of Child Death Review in the UK, “For the Scottish Executive, 2005 He noted conflicts and stated that, “once again it falls to Durfee to resolve this issue”. Our experience had value in the UK. Many teams were formed, after a notorious child abuse death, by advocates on or near the line who were officially not important but knew how to protect children and to share resources.

INTERNATIONAL EFFORTS We have traveled to other countries with presentations at International meetings in Ireland, Australia and England and Canada. We met with Canadian officials in Ottawa. I was asked to present to new teams forming in London. We presented in Porto Portugal and met with experts in France and had contacts for Japan, Lebanon, Israel, England, Australia, New Zealand, China, Singapore, Russia, Sweden, Brazil, Argentina and Netherlands. I was asked to create an international curriculum for the Helfer Society for physicians and the International Society for Child Abuse and Neglect to use internationally.

ISSUES TO CONSIDER

1) TECHNOLOGY VS PEOPLE Technology and science are needed, but this is also a personal issue. The death of a child changes us. Line staff may be casualties. We need to temper the damage but keep the motivation that pain generates.

2) CITIZENS The major resource for children facing fatal and severe damage is the people around them. We encourage people to report but not to act. They can offer a parent help with child care or shopping. Friends, family and neighbors can temper isolation and secrecy that is a major part of the problem.

3) OTHER DEATH REVIEW Child Death Review, AKA, Child Fatality Review has been followed by: Domestic Violence Fatality Review DVFR, Elder Abuse Fatality Review and Dependent Adult Abuse Fatality Review. Domestic Violence Fatality Review exists in multiple nations and includes deaths of children. They serve some of the same families.

4) CHILD AND FAMILY GRIEF Neil Websdale trains DVFR teams, works with ICAN NCFR and shares the concern about children who survive fatal family violence. ICAN has a nine year old annual conference on child grief and trauma. We shared speakers on fatal family violence that is visible at http://www.youtube.com/watch?v=eYWxSmOWKII Neil has a video on a case with multiple child victims. http://vimeo.com/15147441 .

5) TEAM CONFLICT A common split in multiagency Child Death Review Teams causes a separation of criminal justice and human services. Major systems for "fatal child abuse" miss the word homicide that is common with some variation to Coroner, Law Enforcement, Vital Statistics and Prosecutors. Criminal justice data is part of this work.

6) TERMINOLOGY Coroners, law enforcement, and prosecutors use the word Homicide. Social services and media use fatal child abuse / neglect. We store data in handwritten documents and lump data tied as if Homicide, Abuse, Neglect, are the same.

7) PREVENTION VS INTERVENTION Some child fatality review teams believe that investigation and prevention must be separate. My 35 years with multiagency teams finds these activities more than compatible. They can support each other.

8) A SINGLE AGENCY–Various studies note 25-50% of fatal child abuse have previous CPS records. That means that 50- 75 % don't. CPS agencies may not be the local leader or investigator. These cases require multiple agencies working together mixing skills

9) FUNDING Funds and official status can create and destroy. If several people apply for the same grant, the grant score could include points for describing how the applicants will work with others applying for the funds. Grant funds should not separate programs.

10) CORONERS VARY California Coroners may be in Sheriffs Department. Other states may elect or appoint them. Some are morticians. Coroner Investigators may have a police background, but in recent years include Public Health Nurses that work well with infant toddler cases. Medical examiners may not be trained on infant toddler autopsy. The National Association of Medical Examiners, NAME is a resource working on this.

11) MIXED JURISDICTIONS. A child from Maryland injured in Virginia could be sent to Washington National Children's Hospital in Washington DC. If the child dies there could be a case with Maryland Child Protective Services for home of residence, Virginia Law Enforcement for the crime, and DC for medical care and coroner autopsy.

DATA IS A MAJOR ISSUE THAT IS MORE THAN NUMBERS

DATA The large scale national attempts to collect national data will only succeed when local data is improved. The issue of data is expanding with the growth of computer systems. Some simple models are possible using infants and the designation of homicide. I presented the ICAN study of infant homicide data that is lost in transfer from Coroner to Vital Statistics at the national conference for the National Center for Health Statistics and the National Association for Public Health Statistics and Information Systems. There was interest but no data repair.

Issues for local case managers need to mix data from different professions and different jurisdictions. Criminal justice data would include the FBI UCR SHR and criminal court outcome. DCFS and civil court outcome may display previous contact and show intervention with surviving siblings. Different jurisdictions will appear in criminal, social service and health data sets with access to cross lines between counties, states and international boundaries. We gather data on family risk factors while we miss other agency data and fail to gather data on our own action and inaction. When children die we need to measure ourselves.

COLD DATA AND HOT PAIN Case Review should be one case at a time. Done well the case presentation can capture the child and family as people and help others, for a moment create a personal sense of loss. Pictures of the child can make the child real. The words for the story and the picture are important. There is a balance between cold data and personal images. The team review can help professional staff feel less alone. The cold data may be easier to work with.

HOSPITALS ARE A MAJOR MISSING RESOURCE

HOSPITALS – Fatal child maltreatment lends itself to multiagency investigation, but the child needs to die before the review. The ICAN hospital program provides a program with liaison today in 126 hospitals including 32 PICU, 12 child burn programs, the majority of inpatient services for injuries under age three, about half of such children in Emergency Departments and about half of all births. Some hospitals and ICAN are working on software to automate systems. Hospitals probably have contact with the majority of children before their death. Hospitals are also the major private sector program in a field that is primarily government.

This system of hospitals includes peer support as a resource for quality control and program management. This system will first connect hospitals to themselves using computer data systems. Multiple models exist with growing connections from a national working group.

ICAN software is designed to fit the needs of hospitals that do not spend time on this issue and also meet the needs of staff who want to pursue details of child abuse. The digitized report can be sent to the investigating agency and digitized medical records can be added. There are also data elements to allow tracking and monitoring of case management. Guidelines for Ad Hoc team formation will allow joint case management with the hospital. Fatal cases can be tied to local child death review. Children who require intensive care can be designated nonfatal severe abuse for that special review.

This system is designed in part by previous experience in public health 1981-1986. We began with six hospitals with Suspected Child Abuse and Neglect, SCAN teams. By year five that had grown from 6 to 30 hospitals with SCAN teams and the number or reports had grown from 50 a month to 500 a month.

HOMICIDE SOFTWARE AND SYSTEMATIC CASE MANAGEMENT

This custom software is designed to define and automate multiagency records of value with child homicide cases with caretaker suspects. This system will begin with homicide but spread to other cause and manner of child death. This model began with a list of 20 records that were collected by an attorney in the LA County Dependency Court. Additional records were added and the software is approaching a beta version that can be tested by Child Death Review Teams. Both software programs should be available in 2013.

The homicide software will be managed on the Internet. Security measures roughly match or exceed the basic systems used to protect financial activity on the Internet. The access to medical records will make multiagency interaction easier. The review team can access records during review. The computer system can create reports and a system can be devised to monitor the quality of review.

PROTOCOLS MAY BE CREATED AND IMPLEMENTED

HISTORY The data collection instrument in the ICAN Hospital Software will help record collection. Previous well child medical records can increase the understanding of the child's health. However, many teams avoid investigation. LA County has seen 1,000 cases of homicide by caretaker since the team began in 1978. The experience of reviewing those cases leaves us impressed that multiagency review is useful for the investigation and should begin ASAP

There are special issues with investigation of the death of young children. DNA or other evidence can put a suspect at the scene of a crime. That may help with a suspect who should not have been at the scene but have no value if the child and perpetrator are supposed to be together. Young victims, particularly infants, are easier to kill and may have no visible lesions. If suffocated, there may be no findings and what happened may only come with confession.

Witness interviews are a special issue. Child witnesses may or may not quality for court, but may be able to provide critical evidence. The best person to perform these interviews may not be law enforcement. People who work with infants and toddlers will need help to address violent themes and law enforcement may need help with infants and toddlers.

There are some protocols for investigation. Bill Walsh, Dallas PD, created one for USDOJ in 2005 Steve Clark from Occupational Research Assessment in Michigan helped create the protocols *and training material for Sudden Unexpected Infant Death Investigation, SUIDI.* Victor Vieth DA now in Wisconsin provided us material from the National District Attorneys Association.

NONFATAL SEVERE CHILD ABUSE REVIEW

A growing number of states have some defined process for review of nonfatal severe child abuse. There are federal and state legal issues for these cases. Some child death review teams review such cases. Maine began some years ago because they had time with small numbers of deaths. Oklahoma built a separate team for review of cases reported from two hospitals Pediatric Intensive Care Units, PICU. California DSS asks counties social services for numbers for a state report. In 2013 the California network will begin connecting staff from PICU and building a system to identify PICU reports.

JOINT REVIEW OF CHILD AND DOMESTIC VIOLENCE

La County teams for child and domestic violence fatality review met to share two cases where fathers killed multiple children because their wife was going to leave. The reviews were useful for both teams and that review helped build bridges for future similar cases. That theme has been repeated at the ICAN conference on traumatic grief.

PROPOSED LEGISLATION AND RECOMMENDATIONS

The **central focus of the legislation** as presented for this hearing **is child protective service and child welfare systems.** These are important services but some would disagree with the emphasis on CPS The suggested focus, could create a commitment that would be hard to change. The first task I would suggest would also feature a mix of:
1 **prevention and intervention**. Both are necessary and they can support each other
2 **Addition of nonfatal severe cases** to expand prevention and early intervention
3 **Multiple professions working together** as it is with child death review

The first assessment would gather advice from multiple bodies.

HEALTH 1) The American Academy of Pediatrics has a strong history of work with child abuse including two Presidents and committees, 2) The Ray Helfer Society includes physicians who work with child abuse. They have created pediatric boards in child abuse and training fellowships 3) The National Association of Children's Hospitals and Related Institutions, NACHRI has a national study of child abuse programs in Children's Hospitals, 4) ICAN California Hospital Network and informal national working group have systems for peer support and for computer automation of child abuse reports.

PUBLIC HEALTH – 1) The American Public Health Association has a Forum on Family Violence and a Section on Health Informatics Information Technology, 2) Programs at CDC address violence and programs exist at NIH and HRSA.

JUSTICE 1) US Department of Justice has multiple programs. 2) There may be resources in national law enforcement associations. 3) The National Association for Medical Examiners, NAME, has roles with justice and health, 4) The National District Attorneys Association's National Center for Prosecution of Child Abuse 5) The National Association of Juvenile and Family Court Judges 6) Steve Clark with Sudden Unexpected Infant Death Investigation Protocols 6) Dallas Police Dallas Annual Training Conference

TEAMS 1) The network of teams and multistate clusters 2) ICAN National Center on Child Fatality Review 3) Michigan National Center for Child Death Review

CHILD PROTECTIVE SERVICES 1) National Association of Child Welfare Director, 2) National Association of Social Workers, NASW

OTHERS – 1) US Department of Defense, child death review teams 2) Children's Alliance has child advocacy centers that supply specialized evaluations of children for court.

DOMESTIC VIOLENCE – 1) Domestic Violence Fatality Review Training - Neil Websdale 2) Futures without violence San Francisco 3) Dr Jacqueline Campbell at Johns Hopkins

RESOURCES AND POTENTIAL RESOURCES

1) MULTIAGENCY TEAMS – There is no single central agency to do this work. The **teams** are the closest with a multiagency model. For Child Death Review, core Membership includes Coroner, Law Enforcement, Child Welfare, Health, Public Health, Schools, Civil Law, Criminal Law, Central focus for local multiagency teams could use a **national counterpart team**, perhaps USDHHS, USDOJ and USDOD with counterparts from other federal and national organizations.

2) **HEALTH SYSTEMS** Almost all babies are born in hospitals. One exception would be babies killed on the day they are born and those mothers might enter a hospital afterwards for medical care. Hospitals also see injuries and provide special care for trauma and burns. Most hospitals are private and offer a resource separate from the maze of government agencies

3) **DEATH REVIEW** There may be **1,000 multiagency child fatality review teams** in the US and a growing number of Domestic Violence Fatality Review Teams that may serve the same families.

4) **PREVENTION PROGRAMS**: Prevention Programs include Safe Sleeping, Safe Surrender, Don't Shake Your Baby and programs to prevent death from drowning and motor vehicle injury

5) **RISK PROGRAMS** – Home Visitors, Substance Abuse and Pregnancy and Program for underserved high risk pregnancy from child sex abuse and developmentally disabled mothers,

6) **GRIEF PROGRAMS** and **child trauma programs** for child survivors of fatal family violence

7) **CONNECTIONS BETWEEN AGENCIES** and professions with a focus on creating resources for line case managers. That is different from major funds for new staff and different from creating complex central data for data experts to analyze.

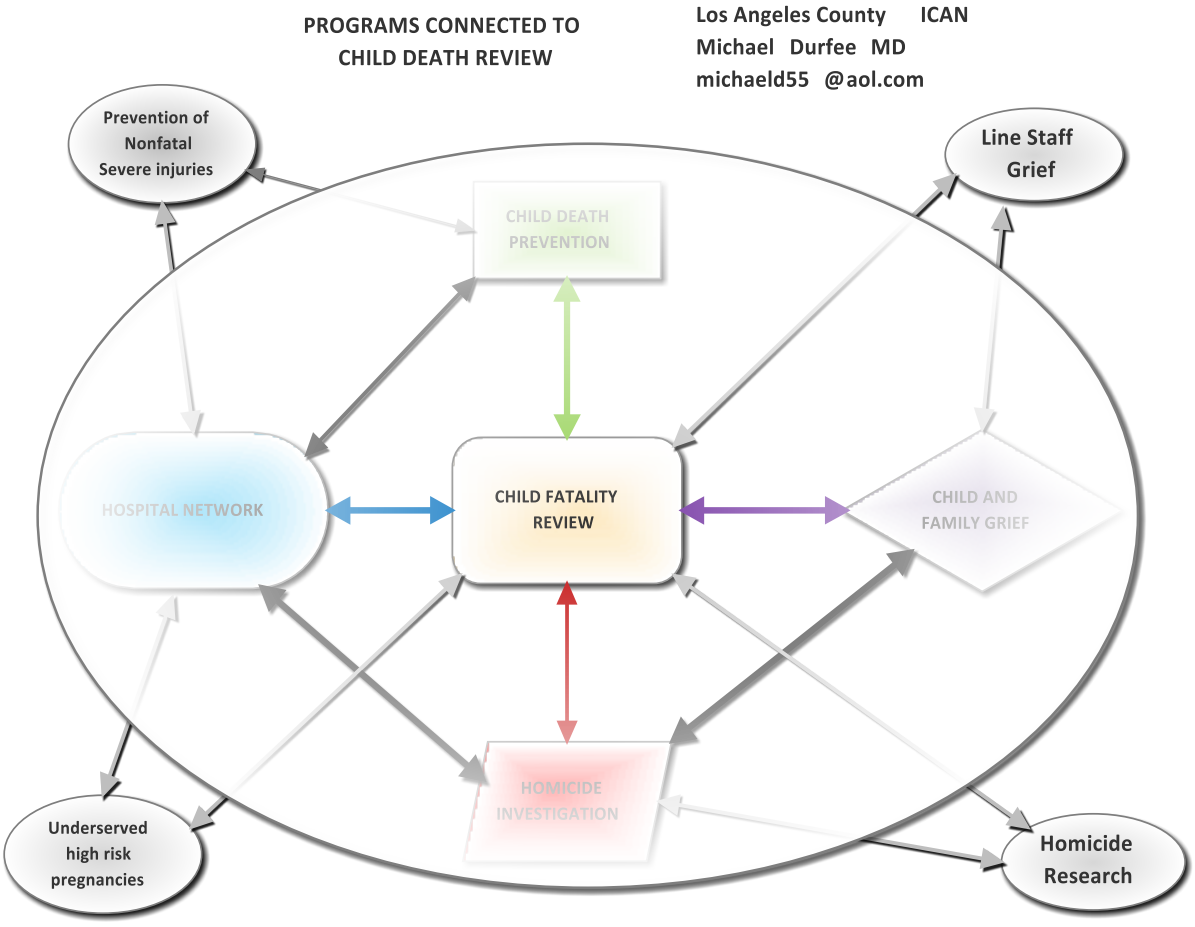
8) **Nonfatal severe child abuse review** should be reachable with hospitals and software. That software can address all reported cases as a population. Data study can provide direction to future screen evaluation and case management.

9) The **ICAN CUSTOM SOFTWARE** for hospitals and software for multiagency Child Fatality Review . Both of these programs should be available soon. The ICAN informal national working group on hospital and Child Fatality Review software has other models.

10) MEDIA NEWS **coverage** continues and a computer alert can scan various news. The news educates the public and prevents history.

A LESSON FROM HISTORY

The experience of French Physician Ambrose Tardieu may help us prepare for resistance that might otherwise surprise us. Dr Tardieu wrote about child abuse, including fatal abuse, in 1760 when we were beginning our Civil War. His work in French was detailed, clear and hopeful. But, almost nothing happened. The next medical article to address fatal child abuse was The Battered Child Syndrome, by Henry Kempe MD, 1962, 102 years later. This country did not develop many programs for fatal child abuse until the 1990s and we are generally cautious or seeking simple rapid cures. This journey may last longer than anticipated.



The programs on this chart are essentially new. The varied and open connections between these programs are also new. Most of this was created with little money.